



Confidential Health Form

Full Name _____ Gender _____

Date of Birth _____ School Applying For _____ Beginning Date _____

Height _____ Weight _____

Personal History: Please answer all questions. Have you ever had the following conditions or procedures? Explain any "Yes" answers in the space provided.

Skin Condition _____

 Eye Trouble _____

 Ear Trouble _____

 Head Injury _____

 Epilepsy _____

 Fainting Spells _____

 Mental Nervous Disorder _____

 Weakness _____

 Paralysis _____

 Insomnia _____

 Shortness of Breath _____

 Hay Fever/Asthma _____

Heart Trouble _____

 High Blood Pressure _____

 Low Blood Pressure _____

 Rheumatism/Arthritis _____

 Back Problems _____

 Dislocation of Joints _____

 Broken Bones _____

 Eating Disorder _____

 Stomach/Duodenal Ulcer _____

 Gall Bladder Problems _____

 Intestinal Troubles _____

 Recurrent Diarrhea _____



Confidential Health Forms (Continued)

Kidney Disease _____

Anemia _____

Venereal Disease _____

Tumor/Cancer _____

Jaundice _____

Hepatitis _____

Allergies

Food _____

Penicillin _____

Sulfonamides _____

Serum _____

Other _____

Surgery

Appendectomy _____

Hernia _____

Tonsillectomy _____

Other _____

Females Only

Irregular Periods _____

Severe Cramping _____

Excessive Flow _____

Current Pregnancy _____

Previous Pregnancy _____

Explain any other health issues, medical conditions, or physical handicaps. _____

Are you currently under a doctor's care for any condition? _____

Are you taking medication at this time? _____

Do you have a history of emotional instability or psychiatric treatment? _____



Confidential Health Forms (Continued)

Blood Type _____

Have you had any of the following?

- Chicken Pox Measles/Rubella Tuberculosis Pertussis
- Scarlet Fever Mumps Other _____

Have you or any of your relatives ever had any of the following communicable diseases?

- Tuberculosis _____
- Hay Fever _____
- Arthritis _____
- Heart Disease _____
- Diabetes _____
- Convulsions _____
- Stomach Disease _____
- Epilepsy _____
- Kidney Disease _____
- Hypertension _____
- Asthma _____
- Cancer _____

If necessary, are you able to walk 3-4 miles per day? Yes No

Insurance

Health Insurance Company _____

Insurance Policy Number _____

Emergency Contact

Name(s) _____ Relationship _____

Phone () _____ Home Cell Work

Additional () _____ Home Cell Work